HEALTH AND WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2005 Legislative Session

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0501

NOTICE OF RULEMAKING - TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is March 1, 2004.

AUTHORITY: In compliance with Section 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

To better protect the health and safety of Idahoans, these rules are being amended to allow for Medicaid coverage of an investigational/experimental medical procedure when the medical review process indicates that such a procedure is necessary and would benefit the health of the participant.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate since it is necessary for the protection of the public health, safety, or welfare.

FEE SUMMARY: There is no fee or charge being imposed or increased in this docket.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary rule, contact Leslie Clement at (208) 364-1804.

DATED this 20th day of December, 2004.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0501

061. -- 064~~2~~3. (RESERVED).

064. COVERAGE OF INVESTIGATIONAL/EXPERIMENTAL PROCEDURES OR TREATMENTS.
The Department may consider Medicaid coverage for investigational/experimental procedures or treatments on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. For these cases, a focused case review is completed by a professional medical review organization to determine if an investigational/experimental procedure would be beneficial to the participant. The Department will determine coverage based on this review. (3-1-04)T

01. Focused Case Review. A focused case review consists of assessment of the following: (3-1-04)T

a. Health benefit to the participant of the proposed procedure or treatment; (3-1-04)T

b. Risk to the participant associated with the proposed procedure or treatment; (3-1-04)T

c. Result of standard treatment for the participant's condition, including alternative treatments other than the requested procedure or treatment; (3-1-04)T

d. Specific inclusion or exclusion by Medicare national coverage guidelines of the proposed procedure or treatment; (3-1-04)T

e. Phase of the clinical trial of the proposed procedure or treatment; (3-1-04)T

f. Guidance of the proposed procedure or treatment by national organizations; (3-1-04)T

g. Clinical data and peer-reviewed literature pertaining to the proposed procedure or treatment; and (3-1-04)T

h. Ethics Committee review, if appropriate. (3-1-04)T

02. Additional Clinical Information. For cases in which the Department determines that there is insufficient information from the focused case review to render a coverage decision, the Department may, at its discretion, seek an independent professional opinion. (3-1-04)T

03. Coverage Determination. The Department will make a decision about coverage of the investigational/experimental procedure or treatments after consideration of the focused case review and any additional information received during the review process. (3-1-04)T

065. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY MEDICAL ASSISTANCE.

The following services, treatments, and procedures are not covered for payment by the Medical Assistance Program: ~~*(5-15-84)*~~(3-1-04)T

01. Service Categories ~~*Excluded*~~ Not Covered. The following ~~*categories of*~~ service categories are ~~*excluded from MA payment*~~ not covered for payment by the Medical Assistance Program: ~~*(5-15-84)*~~(3-1-04)T

a Acupuncture services; ~~*and*~~ ~~*(5-15-84)*~~(3-1-04)T

b. Naturopathic services; ~~*and*~~ ~~*(5-15-84)*~~(3-1-04)T

c. Bio-feedback therapy; and (11-10-87)

d. Fertility-related services, including testing. ~~*(11-10-87)*~~(3-1-04)T

02. ~~*Procedures Excluded*~~ Types of Treatments and Procedures Not Covered. The costs of physician and hospital services for the following types of treatments and procedures are ~~*excluded from MA payment. This includes both the procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure*~~ not covered for payment by the Medical Assistance Program: ~~*(6-1-86)*~~(3-1-04)T

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; ~~*or*~~ ~~*(6-1-86)*~~(3-1-04)T

b. Cosmetic surgery, excluding reconstructive surgery ~~*which*~~ that has prior approval by the Department; ~~*or*~~ ~~*(7-1-98)*~~(3-1-04)T

c. Acupuncture; ~~*or*~~ ~~*(6-1-86)*~~(3-1-04)T

d. Bio-feedback therapy; ~~*or*~~ ~~*(6-1-86)*~~(3-1-04)T

e. Laetrile therapy; ~~*or*~~ ~~*(6-1-86)*~~(3-1-04)T

~~***f.*** *Organ transplants; lung, pancreas, or other transplants considered investigative or experimental procedures and multiple organ transplants; or* *(10-1-91)~~

~~***g.***~~**f.** Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial inseminations, consultations, counseling, office exams, tuboplasties, and vasovasostomics~~.~~; ~~*(11-10-87)*~~(3-1-04)T

~~***h.***~~**g.** New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and ~~*which*~~ that are excluded by the Medicare program are ~~*excluded from MA payment*~~ not covered by the Medical Assistance Program; ~~*or*~~ ~~*(5-15-84)*~~(3-1-04)T

~~***i.***~~**h.** Drugs supplied to patients for self-administration other than those allowed under

the conditions of Section ~~*126*~~ 805; ~~*or*~~ ~~*(12-31-91)*~~(3-1-04)T

~~*j*~~i. Examinations: (6-1-86)

i. For routine checkups, other than those associated with the EPSDT program; ~~*or*~~ ~~*(6-1-86)*~~(3-1-04)T

ii. In connection with the attendance, participation, enrollment, or accomplishment of a program; or (6-1-86)

iii. For employment. (6-1-86)

~~*k*~~j. Services provided by psychologists and social workers who are employees or contract agents of a physician, or a physician's group practice association except for psychological testing on the order of the physician; ~~*or*~~ ~~*(6-1-86)*~~(3-1-04)T

~~*l*~~k. The treatment of complications, consequences, or repair of any medical procedure~~,~~ in which the original procedure was ~~*excluded from MA coverage*~~ not covered by the Medical Assistance Program, unless the resultant condition is life-threatening as determined by the ~~*MA Section of the*~~ Department; ~~*or*~~ ~~*(5-15-84)*~~(3-1-04)T

~~*m*~~l. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service are ~~*excluded from MA payment.*~~ not covered by the Medical Assistance Program; ~~*(5-15-84)*~~(3-1-04)T

~~*n*~~m. Eye exercise therapy~~.~~; or ~~*(10-25-88)*~~(3-1-04)T

~~*o*~~n. Surgical procedures on the cornea for myopia. (3-2-94)

03. Experimental Treatments or Procedures. Treatments and procedures used solely to gain further evidence or knowledge or to test the usefulness of a drug or type of therapy are not covered for payment by the Medical Assistance Program. This includes both the treatment or procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure. Experimental treatments and procedures are not covered for payment by the Medical Assistance Program under the following circumstances: (3-1-04)T

a. The treatment or procedure is in Phase I clinical trials in which the study drug or treatment is given to a small group of people for the first time to: (3-1-04)T

i. Evaluate its safety; (3-1-04)T

ii. Determine a safe dosage range; and (3-1-04)T

iii. Identify side effects; (3-1-04)T

b. There is inadequate available clinical/pre-clinical data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or (3-1-04)T

c. Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (3-1-04)T

(BREAK IN CONTINUITY OF SECTIONS)

081. ORGAN TRANSPLANTS.
The Department may *purchase* reimburse for organ transplant services for bone marrows, kidneys, hearts, intestines, and livers when provided by hospitals approved by the *Health Care Financing Administration* Centers for Medicare and Medicaid for the Medicare program and that have completed a provider agreement with the Department. The Department may *purchase* reimburse for cornea transplants for conditions where such transplants have demonstrated efficacy. *(3-15-02)*(3-1-04)T

***01. Heart or Liver Transplants**. Heart or liver transplant surgery will be covered.* *(3-15-02)*

02. Kidney Transplants. Kidney transplant*ation* surgery will be covered only in a renal transplantation facility participating in the Medicare program after meeting the criteria specified in 42 CFR 405 Subpart U. Facilities performing kidney transplants must belong to one (1) of the End Stage Renal Dialysis (ESRD) network area's organizations designated by the Secretary of Health and Human Services for Medicare certification. *(10-1-91)*(3-1-04)T

03. Living Kidney Donor Costs. The transplant costs for actual or potential living kidney donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery. (10-1-91)

04. Intestinal Transplants. Intestinal transplant*ation* surgery will be covered only for patients with irreversible intestinal failure, and who have failed total parenteral nutrition. *(3-15-02)*(3-1-04)T

05. Coverage Limitations. *When the need for transplant of a second organ such as a heart, lung, liver, bone marrow, pancreas, or kidney represents the coexistence of significant disease, the organ transplants will not be covered.* *(10-1-91)*(3-1-04)T

a. Multi-organ transplants may be covered when: (3-1-04)T

i. The primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process; and (3-1-04)T

ii. The damage to the second organ will compromise the outcome of the transplant of the primary organ. (3-1-04)T

***a*b.** Each kidney or lung is considered a single organ for transplant; (10-1-91)

~~*b*~~**c.** Retransplants will be covered only if the original transplant was performed for a covered condition and if the retransplant is performed in a Medicare/Medicaid approved facility; (10-1-91)

~~*c*~~**d.** A liver transplant from a live donor will not be covered by the Medical Assistance Program; ~~*(3-15-02)*~~(3-1-04)T

~~***d.*** *Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts or ventricular assist devices are not covered;* *(10-1-91)*~~

e. ~~*Except for cornea transplants, all*~~ No organ transplants are ~~*excluded from MA payment*~~ covered by the Medical Assistance Program unless prior ~~*pre*~~authorized by the Department or its designee, and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy. ~~*(3-15-02)*~~(3-1-04)T

~~***06. Noncovered Transplants****. Services, supplies, or equipment directly related to a noncovered transplant will be the responsibility of the recipient.* *(10-1-91)*~~

0~~7~~5. Follow-Up Care. Follow-up care to a recipient who **Temporary Rule**ital not approved for organ transplantation. (10-1-91)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0502

NOTICE OF RULEMAKING - TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is March 1, 2005.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

Approximately two years ago individuals receiving cash assistance through the Division of Welfare were converted to Medicaid with their existing assessed level of care. However, when individuals were re-assessed using the Department's Uniform Assessment Instrument, their level of care was generally assessed at a lower level than when they entered the program. After analysis, it was discovered that the UAI did not sufficiently score individuals who had behavioral issues because it was designed primarily to assess physical functional capabilities. This proposed rule change will create a unique identifier in the UAI that will identify persons living in Certified Family Homes and Assisted Living Facilities with specific diagnosis of mental illness, mental retardation and/or Alzheimer's Disease at a unique level of care that reflects behavioral needs and ties to an established reimbursement rate. This rule change adds an additional level of care which reflects minimum resources needed for providing services to individuals with specific behavioral needs of 12.5 hours per week of personal care services based on documented diagnosis of mental illness, mental retardation, or Alzheimer's Disease. The dollar amounts used as maximum calculated fees were deleted because they are outdated and not used at this time. The calculations now use a uniform term for the calculated fee.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because the rule change is conferring a benefit. Providers will be able to receive a greater reimbursement for Medicaid participants and access for participants with these diagnosis should improve.

FEE SUMMARY: There is no fee or charge being imposed or increased in this docket.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Chris Baylis at (208) 364-1891.

DATED this 16th day of December, 2004.

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THE FOLLOWING IS THE TEXT FOR DOCKET NO. 16-0309-0502

148. PROVIDER REIMBURSEMENT FOR PERSONAL ASSISTANCE SERVICES.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department pursuant to Section 39-5606, Idaho Code, on an annual basis. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-30-01)

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMU under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as follows: (3-30-01)

a. Annually Medicaid will conduct a poll of all Idaho nursing facilities and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used for the reimbursement rate to be effective on July 1 of that year. (3-30-01)

b. Medicaid will then establish payment levels for personal assistance agencies for personal assistance services as follows: (3-30-01)

i. Weekly service needs of zero to sixteen (0-16) hours under the State Medicaid Plan, or a HCBS waiver:

Personal Assistance Agencies	WAHR x 1.55	=	$ amount/hour

(3-30-01)

ii. Extended visit, one (1) child (eight and one-quarter (8.25) hours up to twenty-four

(24) hours):

Personal Assistance Agencies	(WAHR x actual hours of care up to 5 hours x 1.55) plus ($.65 x 1.55 hours on site on-call)	=	$ amount/hour *(Maximum $ 63.65)*
Licensed Child Foster Homes	(WAHR x actual hours of care up to 5 hours x 1.22) plus ($.65 x 1.22 x actual hours on site on-call)	=	$ amount/hour *(Maximum $ 60.36)*

(3-30-01)(3-1-05)T

iii. Extended visit, two (2) children (eight and one-quarter (8.25) hours up to twenty-four (24) hours):

Personal Assistance Agencies	(WAHR x actual hours of care up to 4 hours) x (1.55 plus $.65 x 1.55 x hours on site on-call)	=	$ amount/hour *(Maximum $ 54.26)*
Licensed Child Foster Homes	(WAHR x hours actual care up to 4 hours x 1.22) plus ($.65 x 1.22 x hours on site on-call)	=	$ amount/hour *(Maximum $ 44.33)*

(3-30-01)(3-1-05)T

iv. Adult participants living in Residential/Assisted Living Facilities (RALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (5-3-03)

(1) Reimbursement Level I - One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. *(5-3-03)*(3-1-05)T

(2) Reimbursement Level II - One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. *(5-3-03)*(3-1-05)T

(3) Reimbursement Level III - Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. *(5-3-03)*(3-1-05)T

(4) Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, mental retardation, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, mental retardation, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 148.02.b.iv.(3) of these rules. (3-1-05)T

c. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-30-01)

d. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Client evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMU. (1-1-91)

i. The number of supervisory visits by the RN or QMRP to be conducted per

calendar quarter will be approved as part of the PCS care plan by the RMU. (3-30-01)

ii. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMU. (1-1-91)